



TEXAS DEPARTMENT OF INSURANCE

Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

ELITE HEALTHCARE FORT WORTH

Respondent Name

INDEMNITY INSURANCE CO OF NORTH AMERICA

MFDR Tracking Number

M4-14-3205-01

Carrier's Austin Representative

Box Number 15

MFDR Date Received

JUNE 23, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have provided the ORIGINAL CLAIM showing the ORIGINAL CLAIM DATE when these were first submitted to the carrier."

Amount in Dispute: \$369.57

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The bill in question was disputed based on an extent of injury dispute. Our position is the MFDR cannot be resolved until the extent of injury dispute is finally adjudicated. We are attaching a copy of the pln11 that identifies the extent of injury dispute. In addition per Rule 133.307 (c)(1)(A), the requests for MFDR for dates of service of 7/26/12 and 8/2/2012 are not timely."

Response Submitted by: Broadspire

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 26, 2012 August 2, 2012	CPT Code 99213 Office Visit	\$111.59/ea	\$0.00
August 2, 2012	CPT Code 99080-73 Work Status Report	\$15.00	\$0.00
August 28, 2013	CPT Code 99213	\$116.30	\$0.00
August 28, 2013	CPT Code 99080-73	\$15.00	\$0.00
TOTAL		\$369.57	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
 - W1-Workers compensation state fee schedule adjustment.
 - D10-The time limit for filing has expired.
 - 18-Exact duplicate claim/service.
 - 224-Duplicate charge.
 - 790-This charge was reimbursed in accordance to the Texas medical fee guideline.
 - 075-001-99080 the allowance for this code has been included in the allowed amount in explanation code 080-001.
 - 080-001-Review of this bill has resulted in an adjusted reimbursement for the entire bill of \$0.00.
 - 216-Based on the findings of a review organization.
 - 910-053-Extent of injury, not finally adjudicated.
 - 94-Processed in excess of charges.
 - 97-The benefit of this service is included in the payment/allowance for another service/procedure that has already been adjudicated.

Issues

1. Did the requestor waive the right to medical fee dispute resolution for dates of service July 26, 2012 and August 2, 2012?
2. Does an extent of injury issue exist in this dispute for date of service August 28, 2013?

Findings

1. 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of service in dispute are July 26, 2012 through August 28, 2013. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on June 23, 2014. This date is later than one year after the dates of service in dispute July 26, 2012 and August 2, 2012. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution for dates of service July 26, 2012 and August 2, 2012.
2. Does medical fee dispute resolution have jurisdiction to review codes 99080-73 and 99213 rendered on August 28, 2013? The requestor states that "the extent of injury denial is invalid."

The respondent states that reimbursement is not due because "The bill in question was disputed based on an extent of injury dispute. Our position is the MFDR cannot be resolved until the extent of injury dispute is finally adjudicated. We are attaching a copy of the pln11 that identifies the extent of injury dispute."

Unresolved extent-of-injury dispute: The medical fee dispute referenced above contains unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical billing process.

Dispute resolution sequence: 28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f)(3)(C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent of injury dispute for the claim. 28 Texas Administrative Code § 133.307(c)(2)(K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

Extent-of-injury dispute process: The Division hereby notifies Stephanie Curtis, PA that the appropriate process to resolve the issue(s) of extent of injury, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1. As a courtesy to Stephanie Curtis, PA, instructions on how to file for resolution of the extent of injury issue are attached.

Dismissal provisions: 28 Texas Administrative Code § 133.307(f)(3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers’ Compensation (“Division”). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code § 133.307. 28 Texas Administrative Code § 133.307(c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the extent-of-injury dispute.

For the reasons stated above, the requestor has failed to establish that the respondent’s denial of payment reasons concerning liability for the injured employee’s workers’ compensation claim, compensability of that claim, and/or extent-of-injury issues with that claim have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	<u>06/18/2015</u>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.